

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Smithville Road</b>				d. STREET ADDRESS <b>Smithville Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Henry</b> Last <b>Cluff</b>				4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 3, 1940</b>		9. AGE (In years last birthday) <b>18</b> yrs.	IF UNDER 1 YEAR Months <b>15</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b>15</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Federalsburg, Md., R.F.D.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stanford S. Cluff</b>				14. MOTHER'S MAIDEN NAME <b>Bessie C. Adams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Stanford S. Cluff, Federalsburg, Md., R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal injuries</b> DUE TO <b>912.9</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Proctor turned over on him - Accidents -</b> DUE TO <b>15 months</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>15 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Proctor over turned &amp; fell on him</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>3</b> o. m. <b>8-10</b> p. m. <b>1959</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rural</b>		20f. (City or town) <b>Federalsburg</b> (County) <b>Caroline</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dawson O. George</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dawson O. George, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 14, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Federal Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Adams</b>	

# STATE OF NEW YORK MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, illegible text and markings on the form, including what appears to be a date '1912' and various handwritten notations.]*

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08910

8939

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>				c. LENGTH OF STAY IN lb <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>LEONARD</u> Middle <u>JOHNSON</u> Last				4. DATE OF DEATH Month <u>AUG</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1892</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Elizabeth Boston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>2 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept. 1956</u> , to <u>Aug. 21, 1959</u> , that I last saw the deceased alive on <u>Aug. 21, 1959</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. L. Small</u> M.D.				ADDRESS (Street, city or town, state) <u>Denton Md.</u> DATE SIGNED <u>Aug. 29, 1959</u>			
PHYSICIAN'S NAME (Type) <u>H. L. SMALL M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Aug 29, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Paul</u>		22d. LOCATION (City, town, or county) (State) <u>Near Denton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. W. Moore</u> ADDRESS <u>Denton</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knott</u>	

CERTIFICATE OF DEATH

2000

*[Faint, mostly illegible handwritten text follows, likely containing personal and medical details.]*

1

*[Vertical text on the right margin, possibly a filing or processing note.]*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8940

## CERTIFICATE OF DEATH

08911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>				c. LENGTH OF STAY IN 1b <u>17 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) _____				d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROSE</u> First <u>CONNOLLY</u> Middle <u>LARRIMORE</u> Last				4. DATE OF DEATH <u>Aug</u> Month <u>22</u> Day <u>19</u> Year <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17-1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Connolly</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Shestall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Mary Larrimore</u> Address <u>Ridgely Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>probably 10 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>August 17</u> , 19 <u>59</u> , to <u>August 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>August 22</u> , 19 <u>59</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Paul Knotts</u>		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
PHYSICIAN'S NAME (Type) <u>E. Paul Knotts M.D.</u>		Dent on, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 26-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestersfield</u>		22d. LOCATION (City, town, or county) <u>Quintonville</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Howard Smith of Baltimore, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>DATE AUG 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knott</u>	

CERTIFICATE OF DEATH

2000

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, cause of death, and place of death. The form is divided into several horizontal sections with labels for each field.

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

Vertical text on the right margin, likely a filing or processing stamp.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8941

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>		c. LENGTH OF STAY IN 1b <u>26 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>409 Railroad Avenue</u>				d. STREET ADDRESS <u>409 Railroad Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>F.</u> Last <u>Limore</u>				4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 22, 1886</u>		9. AGE (In years last birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Caroline Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Towers</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-09-5541</u>		17. INFORMANT Address <u>John Limore, Federalsburg, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis Acute</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Astero sclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dawson O. George</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAWSON O. GEORGE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>Aug 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Colin S. Hume</u>	

DATE SIGNED  
8-27-59



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**08913**

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		c. LENGTH OF STAY IN 1b <b>2 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Ridgely</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>				d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Junior</b> <b>Scott</b> <b>Murray</b>				4. DATE OF DEATH Month <b>8</b> Day <b>9</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/1/1924</b>		9. AGE (In years last birthday) <b>34</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer Pet Milk Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Raymond Murray</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Henry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWII</b>		16. SOCIAL SECURITY NO. <b>218-20-5336</b>		17. INFORMANT Address <b>Rebecca Murray Ridgely, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stab wounds in left Chest -</b> <b>982x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Internal Hemorrhage</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr</b> <b>1/2 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Resulted from a Fight</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>6</b> P. M. <b>9-9</b> 19 <b>59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Greensboro Caroline Md</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Dawson O. George</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-10-59</b>	
EXAMINER'S NAME (Type) <b>Dawson O. George</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Henry Burial Ground Ridgely, Maryland</b>		22d. LOCATION (City, town, or county) (State) <b>Greensboro, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaie</b>				24a. REC'D BY REGISTRAR <b>Greensboro, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1944 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE IN CASE

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